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17. ABSTRACT (MAX. 250 WORDS) During a five-year period, a first grade clinic identified, at the start of each school year, children with deviations in behavior, social and emotional adjustment, and mental maturation that might block or retard success in school. These children were referred for further diagnostic evaluations. The program was first tried in one classroom. A three-year study of the group showed that much correction resulted from early identification of progress blocks. The plan was next tried in 30 sections of first graders in a large school system. In six and one-half days 839 children were seen. In the earlier clinics, physical and emotional factors were the main concern; as the techniques and procedures became more familiar, intellectual assessments were instituted.

Personnel involved in the clinic included the nurse, a visiting teacher, a speech correctionist, the school psychologist, a parent, the local school administration, and the classroom teacher.

Clinic operation was divided into two phases: first, the planning and preliminary activities conducted by the nurse, who made arrangements for facilities and personnel, and by the psychologist, who prepared the children psychologically for the experience; and second, the conducting of the main clinic, which included health, dental, speech, personality and mental maturation checks.

Intellectual evaluations were checked against the results of a reading readiness test and against teacher evaluations at the end of the first grade. Clinic ratings tended to be more conservative than the other ratings. Reasons were that the readiness test measured the intellectual component whereas the clinic screened for all types of blocks to school success, and that the teacher evaluations were made after physical and psychological difficulties had already been identified and treated.

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THE FIRST GRADE CLINIC

A MEDIUM FOR EARLY IDENTIFICATION OF PHYSICAL, SOCIAL, EMOTIONAL, AND MENTAL DEVELOPMENT FACTOR THAT MAY TEND TO BLOCK OR IMPEDE SCHOOL PROGRESS

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Date: April 3, 1959

U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
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A MEDIUM FOR EARLY IDENTIFICATION OF PHYSICAL, SOCIAL, EMOTIONAL AND MENTAL DEVELOPMENT FACTOR THAT MAY TEND TO BLOCK OR IMPEDE SCHOOL PROGRESS

The First Grade Clinic as conducted in the Galena Park Schools at the beginning of each school year has as its chief purpose the early identification of deviations in behavior, social and emotional adjustment, and mental maturation that tend to impede or block success in the learning situation. It is in this broad structure that the clinic from its inception has functioned. Such a medium sets into motion also the provision for all phases of special services to come to the assistance of the class teacher to meet individual differences in the curriculum offerings. Hence prevention and correction may be instituted at the very outset of a child's school experience.

There is always a need for some effective way of early identification of student stresses in the learning process. The crux of this problem is to provide some medium of identification within the financial and professional limits of the school concerned. To many districts the cost of obtaining professional competency to identify pupil needs is prohibitive, or it is impossible to secure such services due to the fact that they are unavailable.

The idea, therefore, of a first grade clinic operating within the professional competency of a school situation was born to meet this particular need. The experiment was first tried several years earlier in a smaller school system. It involved only one classroom, with a school administrator acting in the role of coordinator and psychologist, a nurse acting in the role as an evaluator of the physical aspects, a visiting teacher acting in the role of evaluator of the social and emotional aspects,

and senior student assistants acting as clerks and sitting in on the various screening evaluations.

It was found in this particular situation that the judgments made by the various members of the professional staff proved invaluable in helping the teacher to set into motion a school curriculum designed to meet these varied pupil needs. For example, out of a class of thirty-three pupils, three needed speech correction, two needed to be referred to an otologist, seven reflected signs of withdrawal or some type of emotionality and some showed marked aggression. Two were overly aggressive in that they demanded too much attention of the teacher and special privileges. Also, these two children were obviously bright children. Two were slow learners indicated by their repeating the first grade, and one child was repeating the grade for the second time. This latter child was obviously mentally retarded. The remainder of the sixteen showed no obvious difficulty and seemed to be normal, happy children ready to learn. It will be observed that there was one more than half of these children who reflected deviations in overall behavior or physical blocks calculated to impede or block successful school progress.

A three year longitudinal study of this particular group pointed up the fact that a great deal of correction and good came from having been able to identify these differences early in the child's school experience.

The plan was next tried in a larger system where some thirty sections of first grade children were screened, and wherein the school system could provide a greater degree of professionally trained staffing. In the enlarged situation the screening team included a local dentist, two nurses, a speech correctionist, two

visiting teachers, six mothers from the local P.T.A. groups and one psychologist. This staff undertook to see from four to five sections per day, usually four, alloting approximately from 3 to 5 minutes per child. This clinic, conducted in 1954, saw 839 children in six and one-half days. The hearing and visual screening followed the main clinic.

It cannot be over-emphasized that this type of medium is not to be thought of as a diagnostic clinic, but rather a medium in which obvious deviations are pointed up and referrals indicated that call for further diagnostic evaluations. To identify early and set into motion educational planning for the individual child is, therefore, the foremost purpose kept in sharp focus. In other words, a pattern is laid for all facets of professional competency touching the lives of the child as he moves through the learning process.

As indicated above such personnel includes the nurse, the visiting teacher, the speech correacionist, the school psychologist or someone who has some basic training in mental maturation, the parent, the local school administration, and lastly but none the less important, the class teacher.

Setting the stage, therefore, for a clinic in which all these various areas of school personnel can feel that his role is very meaningful to the child's assessment of his readiness for a successful movement through the learning process is the chief function. What is perhaps more important is the bridging in of these areas of service, as a team, to assure the child's success.

There are really two phases of a successful clinic, the first having to do with planning and preliminary activities, and the second the conducting of the main clinic. In the first phase, the

school nurse and the psychologist take the lead. Here the nurse is the key person. It is she who arranges with the principal for clinic facilities in setting up the necessary room situation, explains to the class teacher just what is expected of her, arranges with local mothers to act as clerks or helpers in the clinic, sets up the various stations for the clinic personnel and arranges every detail of clinic operation. Next, the school psychologist or the one to make assessments of mental maturation visits the classroom ahead of time and asks for drawings or any activity that is to be used as a part of the clinic. This is a good time also to allay fears and give some idea of what the experience will be like to the child. The nurse can do this sort of thing very well if the psychologist so desires.

In the second phase, once the preliminaries are complete and the day for the clinic arrives, the personnel should meet thirty minutes early and go over the mechanics of operation to have a better organized operation.

The actual operation of the clinic can best be described by giving the procedures and techniques used by the various personnel: A nurse goes to the classroom accompanied by a mother who relieves the teacher. One-half of the class stays while the other is being taken through the line. This is done to allay newness panic and to facilitate line order. The lead student is accompanied by the nurse and teacher. On reading the door, the children are met by another nurse. Each child carries in his hand a health card clipped to a sheet on which the drawing has been made. The nurse weighs and measures him. A mother, acting as a recorder, puts all information on the health card. The nurse also assesses the general health; such as bone structure, enlarged tonsils, and vaccination status. The

child passes next to the dentist whose observations are recorded on either a dental check list or on a white health card. From there the child next passes to the speech correction station where any peculiarity of speech is recorded and tagged for further evaluation by placing on the health card a tag colored to represent the type of deviation.

The visiting teacher next sees the child. It is at this station a very close evaluation is made of the child's tolerance for group participation, ability to follow directions, unusual emotional reactions such as crying, obvious aggression, withdrawing, mannerisms that attract attention, cooperativeness, and environmental awareness. A check list and a summary statement is made by the visiting teacher. At this station a mother completes the health folder and files all observations heretofore made.

The mental maturation assessment is made as a final phase. By this tmme a fairly thorough appraisal of the child's interpersonal relationship capacity has been assessed by watching him in the several relationship situations. The psychologist uses, however, specific tasks in this interview. Such tasks include counting to 10, tying the shoe, knowing the street and house number, knowing the father's vocation, knowing right and left hand, knowing the colors, knowing whether it is morning or afternoon or similar tasks. These tasks checked against the draw-a-man task give the examiner a fair picture of the child's overall mental development for school readiness.

If the child seems to have a high degree of responsiveness along with the ability to answer correctly most of the task questions, he is placed in number one classification. This indicates to the class teacher that the child will have little or no trouble in the

regular curriculum offerings. If some difficulty is indicated but the prognosis is good for early clarificatinn or correction, the child is given a number two. If the child has difficulty in moving through the line and his task performance is low coupled with obvious emotionality, the child is placed in the number three classification. All children who come in the number three classification are automatically referred for an overall assessment. This includes a psychological test and health appraisal or any one factor that seems to base the primary involvment.

It might be added at this point that in the earlier clinics, the physical and emotional factors were primary concerns. As the techniques and procedures became more familiar to the clinic personnel, the intellectual assessment was instituted and refined to the point wherein its use was reliable enough to be used in helping the class teacher to group her children for intensive instruction or in accordance with the individual's peculiar need. The actual grouping, 1-2-3 categories, was not instituted, however, until the 1958-59 term. The teacher requests at this time became so general that it was no longer possible to avoid the responsibility to predict. To offset the danger of being too subjective in the appraisals, the Metropolitan Readiness Test was used as a basic check. on intellect. asses.

In order to ascertain the school success prediction reliability as checked against the Metropolitan Readiness Test, a spot check was made in the Spring of 1959 by taking all the pupils seen in one of the largest elementary schools, along with random classroom situations in several other centers. There is one important fact to be kept in mind in the spot check. The Metropolitan Readiness Test checks mainly the intellectual componen[illegible] for readiness to

perceive. In other words, it does not evaluate the social, emotional and physical components of a child's overall readiness for school.

By way of explanation the weighting of scores in the Metropolitan and teachers opinion proved to be quite difficult. For practical purposes all students ranking as high, average, and superior were placed in number two level and the poor risks in the number three level. The teacher evaluations were secured in latter part of March after approximately seven months in school for the child. The teacher opinion score ratings were arrived at by asking three questions: Has the child had any difficulty? Has he had some difficulty? Has he been in deep trouble? These scores were accordingly arranged in 1 -2 -3 levels.

Of the 139 children seen in this particular school, the clinic identified 35 or 25.2% in number 1 category; 77 or 55.4% in number 2; and 26 or 18.7% in number 3.

The readiness test identified 56 or 40.3% in number 1 category; 61 or 43.9% in number 2; and 21 or 15.1% in number 3.

What do the comparisons tell us? For a more complete explanation let us now turn to the tables carried below.

To reiterate, ratings of 1, 2, and 3 were obtained for these pupils from three different sources. Two of these ratings were obtained in September, 1958, from first grade clinic observers and the Metropolitan Readiness Test. The third was obtained in March, 1959, by the classroom teachers who rated each child in accordance with his school achievement and reading group placement. The means of obtaining and weighting of these ratings are summarized in TABLE I.

TABLE I

METHOD OF OBTAINING RATINGS

Method	Ratings		
First Grade Clinic Observations in Sept. 1958	superior readiness for school, no difficulty indicated	average readiness	below average readiness for school
Metropolitan Reading Readiness Test in Sept., Oct. 1958	rapid reading group	average reading group	slow reading group
Teacher Evaluations of Achievement in March, 1959	superior achievements	average achievement	unsatisfactory achievement

A closer study of the data carried in TABLE II below reflects that the clinic observers more often assigned a rating of two and less frequently a rating of one than was obtained from the reading readiness test recommendatinns or from teacher evaluations. Other differences in frequency of ratings were insignificant.

TABLE II

FREQUENCY OF RATINGS

Method	Ratings						Total	
	1		2		3			
	N	%	N	%	N	%	N	%
First Grade Clinic	35	25.2	77	55.4	26	18.7	138	99.3
Readiness Test	56	40.3	61	43.9	21	15.1	138	99.3
Teacher Evaluation	55	39.6	62	44.5	21	15.1	138	99.3

In accordance with the national range of incidence of superior and very able pupils in a school population, the clinic findings of 35 in the number 1 category, or 25.2%, is more in line with the number of children who can be expected to have little if any difficulty in the learning process. Or stated another way, 5 pupils in

a school population of 139 is far too high for a successful prediction of no difficulty. Again, it will be observed that in the number 3 category, the clinic observers placed 26 children in this level - the teacher - Metropolitan ratings included 21. The data suggests that the clinic, therefore, tended to be more conservative in its predictions for success. Again, considering the national norms of expectancy, the 26 or 18.3 per cent would be more nearly in line with children who can be expected to have extreme difficulty in the learning process.

To point up the disagreement more vividly, then, TABLE III is presented below:

TABLE III

PERCENTAGE OF AGREEMENT WITH TEACHER RATINGS

	Teacher Ratings							
	1		2		3		Total	
	N	%	N	%	N	%	N	%
Test & Clinic Ratings	23	16.6	27	19.4	8	5.8	58	41.8
Test Ratings	43	31	41	29.5	12	8.6	96	69.1
Clinic Ratings	27	19.4	41	29.5	11	7.9	79	56.8

In TABLE III it will be observed that a greater degree of agreement (69.1%) was found between end-of-year teacher evaluations and ratings obtained from the readiness test results than existed between the ratings resulting from clinic observers and teacher evaluations (56.8%).

A correlation of .49 was found to exist between ratings obtained from clinic observations and ratings obtained from the readiness test results. As has been presented in TABLE IV, below, those

these ratings demonstrate approximately the same degree of agreement as did the teacher evaluations and clinic observers ratings.

TABLE IV

READINESS TEST AND CLINIC RATINGS IN AGREEMENT

Ratings							
1		2		3		Total	
N	%	N	%	N	%	N	%
26	18	38	27.3	12	8.6	76	53.9

As pointed out above, the clinic tended to be more conservative in its prediction for success. And, too, the rediness test measured, in the main, the intellectual component while the clinic screened for all types of blocks to school success. Or stated another way, the readiness test suggested placement for reading groups while the clinic did not. The data suggests that the clinic observers considered variables in their ratings not employed in the readiness test.

Further, in checking follow-ups on referrals for all types of suspected difficulties such as physical involvments: speech, tonsils, dental needs, lowered vitality, and the referral made for psychological evaluation, 92% of these were done as a matter of course in the child's first year of school experience. It is believed, therefore, that due to the fact that these difficulties were identified early further diagnosis in alleviating or correcting suspected difficulties were carried out as a matter of providing a good school life for the child.

In psychological testing the range of intellectuality ran from 1.5 to 3.2 years retarded with only three students testing normal or

above out of the 26 referred for psychologicals.

In summary, the First Grade Clinic as a medium of identifying blocks to school progress has been employed in the Galena Park Schools over a period of five years. There has been no pretense made toward diagnosing but rather toward broad screening for the purpose of detecting early symptoms calculated to hinder or block the child's successful movement through school. Rather, much greater emphasis has been placed on the value of activating all phases of special service to aid and assist the class teacher in meeting the child's deficiencies or needs before undesirable patterns of behavior become jelled. Also, where depth of difficulty seems to warrant, the findings are used to make referrals to medical resources, community child welfare agencies, and to institute a close band between home and school in cooperating to alleviate the indicated stress.

Finally, there is need, however, for constant effort for refinement of the instruments used to detect possible deviations as well as longtitudinal research studies to ascertain what happens to these children (18% or above in the school population) that the data suggests will experience grave difficulty in passing through the learning process.

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